Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Physician Quality Reporting Initiative (PQRI) Measures and Specifications

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Quality Measures and Specifications are now available. To access both the measures and measure specifications documents, visit the PQRI web page at *http://www.cms.hhs.gov/PQRI* on the CMS website. Once there, go to the Measures/Codes section of the page and scroll down to the Downloads section. Please note that many of the quality codes are new and will be rejected by Medicare claims processing systems prior to the July 1, 2007 HCPCS update.

MLN Matters Number: MM5603
Related Change Request (CR) #: 5603
Related CR Release Date: June 12, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1265CP
Implementation Date: July 2, 2007

Quarterly Update to Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007

Note: This article was revised on June 12, 2007, to reflect the changes made to CR5603 on that date. The CR release date, transmittal number and Web address for accessing CR5603 were changed. All other information remains the same.

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), durable medical equipment regional carriers (DMERCs), and/or regional home health intermediaries (RHHIs)).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. Key points of CR5603 are as follows:

- CR5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- CR5603 states that Medicare carriers and A/B MACs will deny the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare's DME system (VMS) or carriers system (MCS).
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare's fiscal intermediary shared system (FISS).

With regard to MUEs, providers are reminded of the following:

- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information

To see the official instruction (CR5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME MAC, or RHHI at their toll-free number which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.